STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING _____ B. WING _____	C 04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 4/13/2021 through 4/15/2021. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/13/2021 through 04/15/2021. One complaint was investigated during the survey. VA00049948 was substantiated, without deficient practice. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this 117 certified bed facility was 90 at the time of the survey. The survey sample consisted of eighteen (18) current resident reviews, and three (3) closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to accurately complete an MDS assessment for one of 21residents, Resident #83. Resident #83's discharge status was incorrectly coded as "acute hospitalization."	F 641	1. On 4/14/21 Resident #83 chart was updated to reflect the resident discharged to the community and not an acute hospitalization. 2. Audit of resident discharges within the	5/19/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/30/2021

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F 641	Continued From page 1 Findings were: Resident #83 was admitted on 02/25/2021 with diagnosis including: Type II diabetes mellitus, fibromyalgia, hypertension and mild depressive disorder. The initial MDS (minimum data set) with an ARD (assessment reference date) of 03/04/2021, coded Resident #83 as cognitively intact with a summary score of "14". Resident #83 closed record was identified as "hospital discharge". Review of the progress note section revealed notes dated 03/08/2021 which documented: "3/8/2021 13:07 [1:37 p.m.] Social Services Progress Note: (Resident name) left against medical advice (AMA) today. Social services spoke with (resident name) and her son regarding her wanting to leave and explained what AMA meant. It was explained that home health and equipment could not be ordered and follow up appointment would not be made with her PCP [Primary Care Provider]...both stated verbal understanding of the AMA process. (Resident name) was being followed by APS [adult protective services] prior to coming to facility. Social services called and made (name of APS worker) aware that she was planning on leaving AMA and she stated that she would follow up...the ombudsman was also notified of the AMA discharge via email..." "3/8/2021 18:13 [6:13 p.m.] Nursing Progress Note Patient left AMA, she is her own RP [responsible party]. Verbalized and stated she understood she was leaving against medical advice but wanted to go home. MD made aware."	F 641	last 30 days was completed on 4/14/21 with no other assessment issues noted. 3. In-service education provided by Assistant Director of Nursing and/or designee to MDS Coordinators regarding the importance of accurately coding assessments correctly. MDS Coordinators will run scrubber report after every discharge to ensure MDS assessment is coded correctly. 4. The interdisciplinary team will monitor the reports weekly for 6 weeks and turn results into the Administrator and/or designee for review. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. Date of Compliance 5/19/21	

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F 641	Continued From page 2 The discharge MDS with an ARD of 03/08/2021 was reviewed. In section "A2100 Discharge Status", Resident #83 was coded as being discharged to an "Acute Hospital." On 04/14/2021 at approximately 1:30 p.m., LPN (licensed practical nurse) #2 was interviewed regarding the discharge status coded for Resident #83. She stated, "I didn't do that MDS but I see what you are talking about. It should have been coded that she [Resident #83] was discharged to the community. I will tell [name of other MDS coordinator] and she will do a correction." At approximately 3:00 p.m., LPN #3 called and stated, "I completed the discharge MDS on (name of Resident #83), I went back and looked at it...I incorrectly coded it as a hospital discharge. I have done a correction." The above information was discussed during an morning meeting with the DON (director of nursing) and the administrator on 04/15/2021. No further information was received prior to the exit conference on 04/15/2021.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		5/19/21

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F 658	Continued From page 3 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care for one of 21 residents in the survey sample. Resident #33 was administered the medication alendronate (Fosamax) without following manufacturer recommendations to maximize effectiveness and prevent side effects such as esophagus injury. The findings include: Resident #33 was admitted to the facility on 2/10/21 with diagnoses that included schizophrenia, gastroenteritis, colitis, hypertension, vitamin D deficiency, major depressive disorder, osteoporosis, anemia and bipolar disorder. The minimum data set (MDS) dated 3/2/21 assessed Resident #33 with moderately impaired cognitive skills. Resident #33's clinical record documented a physician's order dated 2/10/21 for alendronate sodium (Fosamax) 35 milligrams (mg) to be given by mouth every Wednesday for treatment of osteoporosis. The resident's medication administration record (MAR) scheduled the alendronate to be given at 8:00 a.m. each Wednesday. On 4/14/21 at 7:45 a.m., a medication pass observation was conducted with licensed practical nurse (LPN #5) administering medications to Resident #33. During this observation, Resident #33 was administered the oral medications folic acid, vitamin D, loperamide, mesalamine, fiber capsule and metoprolol as ordered by the physician. LPN #5 stated the resident was scheduled to get alendronate	F 658	1. Orders from Resident #33 have been updated to reflect additional instructions for taking medication alendronate (Fosamax) to remain upright (sitting, standing or walking) for at least 30 minutes per manufactures recommendations. 2. Review of all residents who have orders for alendronate (Fosamax) and updated orders with special instructions per manufactures recommendations. 3. In-service education provided by the Assistant Director of Nursing and/or designee to ensure Nurses follow manufactures recommendations for medications. The Assistant Director of Nursing and/or designee will complete one medication pass per week to ensure manufactures recommendations are being followed. 4. The interdisciplinary team will monitor the results weekly for 6 weeks and turn results into the Administrator and/or designee for review. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. Date of compliance 5/19/21	

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F 658	Continued From page 4	F 658		

(Fosamax) but she was unable to locate the medication in the cart.

On 4/14/21 at 8:57 a.m., LPN #5 stated she found the alendronate 35 mg and administered the medication to Resident #33 "about 5 minutes ago."

The resident's medication administration record (MAR) documented a note entered by LPN #5 dated 4/14/21 at 8:59 a.m. stating the alendronate was administered.

On 4/14/21 at 8:58 a.m., approximately 10 minutes after the administration of the alendronate, Resident #33 was observed flat in bed on her right side. Certified nurses' aide (CNA #1) was changing the resident's incontinence brief. On 4/14/21 at 9:07 a.m., approximately 20 minutes after the administration of alendronate, Resident #33 was in bed on her back with the head of the bed up approximately 30 degrees.

On 4/14/21 at 9:10 a.m., LPN #5 was interviewed about any special precautions or instructions regarding the administration of alendronate. LPN #5 stated she was not aware of any special considerations with giving the alendronate. LPN #5 reviewed the medication administration record and stated no special instructions were listed with the order. When asked about the resident being flat in bed following the medication and giving alendronate with other medicines, LPN #5 stated again she was not aware of any special precautions when administering the alendronate.

The facility pharmacy/drug information for alendronate was requested. The facility's pharmacy drug information sheet (print date

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F 658	Continued From page 5	F 658		

4/14/21) titled Fosamax (alendronate) documented, "Alendronate is used to prevent and treat certain types of bone loss (osteoporosis) in adults...Alendronate belongs to a class of drugs called bisphosphonates..." Under instructions on how to use alendronate was documented, "...Follow the instructions very closely to make sure your body absorbs as much drug as possible and to reduce the risk of injury to your esophagus...Take this medication by mouth, after getting up for the day and before taking your first food, beverage, or other medication. Take it with a full glass (6-8 ounces or 180-240 milliliters) of plain water...Then stay fully upright (sitting, standing, or walking) for at least 30 minutes and do not lie down until after you first food of the day. Alendronate works only if taken on an empty stomach. Wait at least 30 minutes (preferably 1 to 2 hours) after taking the medication before you eat or drink anything other than plain water. Do not take this medication at bedtime or before rising for the day. It may not be absorbed and you may have side effects..."

The manufacturer's guide for taking Fosamax (revised 8/2019) documents, "...Fosamax can cause serious side effects including...Esophagus problems...Low calcium levels...Bone, joint, or muscle pain...Do not take Fosamax if you...Cannot stand or sit upright for at least 30 minutes...Fosamax works only if taken on an empty stomach...Take Fosamax after you get up for the day and before taking your first food, drink, or other medicine...Take Fosamax while you are sitting or standing...After swallowing Fosamax tablet, wait at least 30 minutes: Before you lie down...Before you take your first food or drink except plain water...Before you take other medicines, including antacids, calcium, and other

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F 658	Continued From page 6 supplements and vitamins..." This guide documented common side effects of Fosamax as stomach area pain, heartburn, constipation, diarrhea, upset stomach and bone/joint pain. (1) This finding was reviewed with the administrator and director of nursing during a meeting on 4/14/21 at 5:00 p.m. (1) Medication Guide Fosamax. 08/2019. Merck & Co., Inc., Whitehouse Station, NJ. 4/15/21. https://www.merck.com/product/usa/pi_circulars/f/fosamax/fosamax_mg.pdf	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide nail care for one of 21 residents in the survey sample. Resident #33 was observed with long, thick, distorted toenails described by the resident as causing discomfort. The findings include: Resident #33 was admitted to the facility on 2/10/21 with diagnoses that included schizophrenia, gastroenteritis, colitis, hypertension, vitamin D deficiency, major depressive disorder, osteoporosis, anemia and bipolar disorder. The minimum data set (MDS) dated 3/2/21 assessed Resident #33 with	F 677	1. Resident #33 toe nails were cut and filed on 4/14/21 by Unit Manager. 2. All residents have been assessed for nail care and appropriate interventions in place. 3. In-servicing will be provided to employees by the Assistant Director of Nursing and/or designee for residents nails should be cleaned and trimmed on resident shower days. If resident is a diabetic, have thick, discolored nails, employee is to report to charge nurse. Charge nurse will attempt to provide nail care and if unsuccessful, a referral to	5/19/21

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F 677	Continued From page 7 moderately impaired cognitive skills and as requiring the extensive assistance of one person for personal hygiene. On 4/13/21 at 11:19 a.m., Resident #33 was observed in bed. The resident was sitting on top of the bed covers with her bare feet/lower legs visible. The toenails on both feet were long, thick and distorted. The great toes nails extended beyond the end of the toe and curved outward. The first toenails on both feet were wrapped over the end of the toe. The other toenails were long, jagged and curved with the nails contacting adjacent toes. The left pinky toenail was brown in color with dry, scaly skin near the toes. On 4/13/21 at 11:20 a.m., Resident #33 was interviewed about her toenails. The resident stated she wanted her toenails cut, as they were long and sometimes hurt. The resident stated she thought she went to a foot doctor once but they did not want to cut the nails. Resident #33's clinical record documented an admission assessment dated 2/10/21 listing the left toenails as discolored, thick and long. The record documented a physician's order dated 2/10/21 for "podiatry as needed." The resident's plan of care (revised 3/2/21) documented the resident required assistance with personal hygiene/care. Interventions to maintain proper hygiene included, "...requires assistance from staff with hygiene...requires skin inspection Q [each] week...Monitor/document/report PRN [as needed] any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function..."	F 677	podiatrist and/or MD for further evaluation. 4. The interdisciplinary team will monitor a total of 5 residents per week for 6 weeks and turn results into the Administrator and/or designee for review. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. Date of Compliance 5/19/21	

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F 677	Continued From page 8	F 677		

There was no record of a podiatry referral or any mention of attempts to cut/trim the resident's toenails.

On 4/14/21 at 12:45 p.m., the certified nurses' aide (CNA #1) caring for Resident #33 was interviewed. CNA #1 stated, "We've been told not to cut toenails." CNA #1 stated she usually cut fingernails during showers but did not usually cut toenails. CNA #1 stated she was not aware the resident's toenails were long and needed trimming.

On 4/14/21 at 12:50 p.m., the licensed practical nurse (LPN #5) caring for Resident #33 was interviewed. Accompanied by LPN #5 and with the resident's permission, Resident #33's toenails were observed. LPN #5 touched the resident's left foot and the resident stated, "Ow, Ow." Resident #33 stated that her toenails "really bug me." LPN #5 stated she was not aware the resident's toenails were long/thick. LPN #5 stated the aides were able to cut toenails unless the resident was diabetic. LPN #5 stated Resident #33 did not have a diabetes diagnosis.

On 4/14/21 at 1:00 p.m., accompanied by the unit manager (LPN #7) and with the resident's permission, Resident #33's toenails were observed. LPN #7 was interviewed at this time about the long, distorted toenails. LPN #7 stated aides were expected to cut toenails unless the resident was diabetic. LPN #7 stated she was not aware Resident #33's nails were long and needed attention. LPN #7 stated if nursing staff was unable to cut the nails, a podiatrist came to the facility once per month to provide needed foot care.

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F 677	Continued From page 9 This finding was reviewed with the administrator and director of nursing during a meeting on 4/14/21 at 5:00 p.m.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility failed to accurately complete an admission and weekly skin assessment for one of 21 Residents, Resident #242. The findings include: Resident #242 was admitted to the facility on 4/1/21. Diagnoses for Resident #242 included: Schizoaffective disorder, adjustment disorder, chronic pain, and pressure ulcer. The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 4/7/21. Resident #242 was assessed with a cognitive score of 2 indicating severely cognitively impaired. Review of Resident #242's medical record included an Admission Data Collection Assessment dated 4/1/21. This assessment	F 684	1. On 4/14/21 Resident #242 was noted to have incorrect assessment data in relation to pressure ulcers. 2. Audit of all recent admissions assessments have been reviewed with in the past 30 days and no other issues have been noted. 3. In-servicing will be provided to employees by the Assistant Director of Nursing and/or designee in relation of accurate and documenting appropriate assessments for all new and readmitted residents. 4. The interdisciplinary team will monitor all new admission assessments weekly for six weeks. Clinical Interdisciplinary team will complete another skin assessment within 24-72 hours of the	5/19/21

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F 684	Continued From page 10 documented Resident #242 was newly admitted with a stage 2 pressure ulcer to the sacrum and an unstageable pressure ulcer to the right heel. The baseline care plan for skin integrity was completed upon admission and dated 4/1/21. The goal for skin integrity was to "Prevent any skin breakdown or injury." Interventions included: Turn every 2 hours and as needed, report skin redness to nurse, provide incontinent care as needed, and use wipes for Resident. A weekly skin assessment dated 4/8/21 documented the right heel with an unstageable pressure ulcer and pressure area to sacrum. There were no measurements or any other description of the pressure ulcers. Another weekly skin assessment dated 4/14/21 indicated that Resident #242 had MASD (moister associated skin damage) to bilateral buttock and scarring noted to the sacrum and left and right buttock. On 04/14/21 at 11:22 AM, Resident #242's heels and buttocks were observed with license practical nurse (LPN) #1. The skin on both heels was intact and resolved. The sacral wound was open to air without drainage and had depth. The wound to the left buttock was dime sized and scabbed over and also wasn't covered with a dressing. LPN #1 was unaware of the staging of the wounds, and stated she does not assess wounds in regards to staging. On 04/14/21 at 12:47 PM, the director of nursing (DON) was interviewed. The DON said Resident #242's pressure ulcers were resolved prior to being admitted to the facility. The wounds that	F 684	resident admit date. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. Date of Compliance 5/19/21	

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F 684	Continued From page 11	F 684		

were observed just happened and the wound clinic had been made aware and completed a skin assessment via "Telemedicine Initial Evaluation."

The DON stated, the admission assessment and weekly skin assessment dated 4/8/21 were incorrect; the pressure ulcers were acquired in the hospital but were healed prior to being admitted to the facility and was uncertain that the nursing staff had actually completed an assessment versus getting information from the hospital records.

Review of the hospital discharge summary documented the pressure ulcers were resolved.

The telemedicine report completed on 04/14/21 documented Resident #242 "[...] has evidence of previously healed pressure injury [...] The possibility of the present wound being of pressure related etiology is low." The report went on to indicate the current wounds were moisture related.

On 04/14/21 at 1:36 PM, registered nurse (RN #2, the nurse doing skin assessment on 4/8/21) was interviewed. RN #2 stated that she thinks that Resident #242 had wounds to the heel and sacrum but didn't know enough to stage them.

On 04/14/21 at 2:59 PM, license practicable nurse (LPN #9) who did the admission assessment was interviewed. LPN #9 did not remember seeing any wounds and couldn't say if Resident #242 did or did not have a pressure ulcer because another nurse was doing the assessment as she was documenting.

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F 684	Continued From page 12 On 04/14/21 at 3:30 PM, Resident #242's admitting physician was interviewed (other staff, OS #3). OS #3 stated although the admission H&P (History and Physical) indicated Resident #242 had pressure ulcers, the pressure ulcers were healed and he had documented in error and meant to document that Resident #242 had a history of pressure ulcer so that the nursing staff could put interventions in place to prevent pressure ulcers from reoccurring. On 04/14/21 at 4:50 PM, the above information was presented to the DON and administrator. The administrator said she didn't feel that Resident #242 had pressure ulcers when entering the facility because that would have been brought up in the morning meeting and treatment would have been put into place and the staff would have obtained measurements on the wounds. The administrator agreed that the staff did not accurately complete skin assessments. No other evidence was presented prior to exit conference on 4/16/21.	F 684		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5 percent. There were five observed	F 759	1. On 4/14/21 Resident #33, #65, #5 were all assessed for improper medication administration and no adverse reactions noted.	5/19/21

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F 759	Continued From page 13 medication errors out of 35 opportunities resulting in 14.2% error rate. The findings include: 1. On 4/14/21 at 7:45 a.m., licensed practical nurse (LPN #5) was observed administering medications to Resident #33. LPN #5 prepared and administered the following medications to Resident #33: folic acid 2 milligrams (mg), vitamin D 50 micrograms (mcg), loperamide 4 mg, mesalamine 1.2 grams (2 tablets), fiber capsule 625 mg and fiber powder (Metamucil) 10 cc (cubic centimeters) mixed in a cup of water. Cholestyramine powder was not included in the administered medications. Resident #33's clinical record documented a physician's order dated 2/10/21 for cholestyramine powder 4 grams/dose with instructions to give 1 packet by mouth twice per day for the treatment of Crohn's disease. Resident #33's clinical record did not include a physician's order for the fiber powder (Metamucil). On 4/14/21 at 9:00 a.m., LPN #5 was interviewed about the fiber powder administered and the omission of the cholestyramine powder. LPN #5 reviewed the resident's medication orders and stated, "I was wrong." LPN #5 stated she gave the fiber powder instead of the prescribed cholestyramine powder. LPN #5 looked in the medication cart and found the prescribed cholestyramine powder provided from the pharmacy in dosed packets. 2. On 4/14/21 at 8:13 a.m., LPN #5 was observed	F 759	2. No other residents noted for medication administration errors and no adverse reactions noted. 3. In-servicing will be provided to employees by the Assistant Director of Nursing and/or designee with the 5 rights of medication. Administration. The five rights being right resident, right medication, right dose, right route and right time. 4. The Clinical team designee will monitor two medication administrations per week for 6 weeks. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. Date of Compliance 5/19/21	

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administering medications to Resident #65. Included in medications administered were two 2500 mcg tablets of sublingual vitamin B-12. Resident #65 swallowed both of the vitamin B12 tablets at once, followed by several sips of water. LPN #5 provided no instruction or prompts to the resident about placing or dissolving the tablets under her tongue instead of swallowing. LPN #5 made no comment or note about the resident swallowing the pills instead of taking them sublingually.

Resident #65's clinical record documented a physician's order dated 4/3/21 for vitamin B-12 tablet sublingual 2500 mcg with instructions to give two tablets sublingually each day for treatment of a vitamin deficiency.

On 4/14/21 at 9:00 a.m., LPN #5 was interviewed about Resident #65's sublingual vitamin B-12. LPN #5 stated she put the sublingual tablets in a separate medicine cup. LPN #5 stated the resident "just took them with water." LPN #5 stated she told the resident the pills were sublingual.

3. On 4/14/21 at 8:13 a.m., LPN #5 was observed administering medications to Resident #65. Included in the medications administered was one tablet of Senna 8.6 mg.

Resident #65's clinical record documented a physician's order dated 4/5/21 for Senna-S 8.6-50 mg (sennosides-docusate sodium) with instructions to give one tablet two times a day for constipation.

On 4/14/21 at 9:00 a.m., LPN #5 was interviewed about the Senna administered instead of the

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ordered Senna-S. LPN #5 made no comment but looked in the medication cart and located a bottle of Senna and a bottle of Senna Plus. The Senna Plus was labeled as matching the physician's order with 8.6 mg of senna and 50 mg of docusate sodium.

These findings were reviewed with the administrator and director of nursing during a meeting on 4/14/21 at 5:00 p.m.

4. On 4/14/2021 at 08:15 AM, during medication administration observation, the licensed practical nurse (LPN #08) administered 38 units of Novolog insulin using an insulin pen. Prior to administration, LPN #08 stated that Resident #5 also received Novolog insulin based on a sliding scale but that his accu-check reading was 163, so he did not need additional coverage.

On 4/14/2021 at 9:05 AM, Resident #5's physician's order set (POS) was reviewed for accuracy following medication administration. The POS documented an order for, "Novolog FlexPen Solution ...inject 38 units subcutaneously before meals ....AND, inject as per sliding scale: if 150 - 200 = 4 ...subcutaneously before meals ..."

On 4/14/2021 at 9:45 AM, LPN #08 was interviewed regarding Resident #5's sliding scale insulin and the additional 4 units of insulin that should have been administered. LPN #08 stated that she only administered 38 units of Novolog insulin and that based on his blood glucose reading he should have received an additional 4 units. LPN #08 also stated she would notify the doctor.

No further information or documentation was presented prior to the exit conference on

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F 759	Continued From page 16 4/15/2021 at 8:30 AM.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure expired medications were not readily available for distribution on one of 3 units, the 400 unit. The findings include:	F 761	1. On 4/14/21 expired medication was immediately discarded. 2. All facility medication carts were audited with no discrepancies found. 3. In-servicing will be provided to	5/19/21

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F 761	Continued From page 17 On 04/14/2021 at 8:35 a.m., medication storage observations were conducted on the 400 unit with licensed practical nurse (LPN #4). Observed on the 400 - West A medication cart was the following opened bottle of medication: Mason Natural K, Vitamin K 100 mcg (micrograms), with an open date of 7/2/19 and expiration date of 2-21 (February 2021). On 04/14/2021 at 8:45 a.m., LPN #4 was interviewed regarding expired medication. LPN #4 stated, "Normally the third shift nurse and/or the unit manager checks the carts for expired medication. However, all of the nurses are responsible for checking for expired medications." A review of the facility's policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes, and Needles, Revision Date 10/31/16" documented the following: " ....4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines: or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier...." " ....5.2 Medications with a manufacturer's expiration date expressed in month and year (e.g. May, 2019) will expire on the last day of the month ...." On 04/14/2021 at 4:45 p.m., the administrator, DON (director of nursing), and corporate staff were informed of the above findings during a	F 761	employees by the Assistant Director of Nursing and/or designee. In-service will include education that all nurses are responsible for checking the expiration date of a medication before administration. 4. The clinical team designee will do an audit of medications carts twice a week for six weeks for expired medications. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. Date of Compliance 5/19/21	

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F 761	Continued From page 18 meeting. No other information was presented to the survey team prior to exit on 04/15/2021.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		5/19/21

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F 880	Continued From page 19 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to follow infection control protocols for hand hygiene on one of three nursing units. A nurse on East wing failed to don gloves and perform hand hygiene	F 880	1. On 4/14/21 employee was immediately in serviced on proper infection control techniques policies and procedures. 2. Employee was in serviced on proper	

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F 880	Continued From page 20 between residents when obtaining fingerstick blood samples for glucometer testing. The findings include: On 4/13/21 at 11:30 a.m., licensed practical nurse (LPN) #6 was observed checking Resident #11's blood sugar using a glucometer. LPN #6, with a glove only on her right hand, used a lancet to stick one of Resident #11's fingertips and applied the blood sample onto a testing strip. After completing the fingerstick and obtaining a blood sugar reading, LPN #6 removed the glove on her right hand and exited the room. Without performing hand hygiene, LPN #6 went to the medication cart located near the nursing desk and recorded the blood sugar reading. LPN #6 then proceeded to Resident #66 with the glucometer. On 4/13/21 at 11:32 a.m., LPN #6 used a lancet to stick Resident #66's fingertip. LPN #6, with a glove only on her right hand, obtained a blood sample from the fingerstick and applied it to the glucometer testing strip. After obtaining a blood sugar reading from the glucometer, LPN #6 removed the right hand glove, exited the room and went to the medication cart. LPN #6 performed no hand hygiene prior to or after performing the fingerstick and blood sugar check with Resident #66. LPN #6 cleaned the glucometer with an alcohol wipe. On 4/13/21 at 11:34 a.m., LPN #6 was interviewed about infection control protocols when performing fingersticks and blood sugar checks with residents. LPN #6 stated she did not perform hand hygiene because she wore gloves. When asked why she had a glove only on one	F 880	hand hygiene, donning and duffing, and obtaining a blood glucose sample. Competencies were completed on each of these with the Director of Nursing/IPC. 3. In-servicing will be provided to employees by the Assistant Director of Nursing and/or designee with proper hand hygiene and infection control protocols and policies. 4. The interdisciplinary team will monitor a total of 5 employees per week for 6 weeks on infection control policies and procedures and turn results into the Administrator and/or designee for review. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. Date of Compliance 5/19/21	

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hand, LPN #6 stated, "I just put on one glove." LPN #6 stated she did not touch any body parts with her left hand.

Without washing hands or using hand sanitizer, LPN #6 then took the glucometer to Resident #34. LPN #6, with gloves on both hands, used a lancet to stick Resident #34's fingertip. LPN #6 applied a blood sample onto the glucometer test strip. After getting a blood sugar reading, LPN #6 took off and discarded the gloves but performed no hand hygiene prior to leaving the room. LPN #6 went to the medication cart located near the nursing desk, recorded the blood sugar reading, cleaned the glucometer with an alcohol wipe and stored it in the cart. Without any hand hygiene, LPN #6 then went behind the desk and began touching and entering information into the desktop computer.

LPN #6 performed no hand hygiene before or after performing fingersticks and applying blood samples to the test strips with Residents #11, #66 or #34 and wore a glove only on her right hand during fingersticks with Resident #11 and Resident #66.

On 4/14/21 at 1:08 p.m., the unit manager (LPN #7) was interviewed about the infection control protocols when performing fingersticks and blood sugar checks. LPN #7 stated the nurse should have worn gloves and performed hand hygiene after removing gloves. LPN #7 stated hand hygiene was expected between contact with residents.

The facility's policy titled Blood Glucose Monitoring & Disinfecting (revised 3/10/21) included the following steps, "...Perform hand

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hygiene...Apply gloves...Wipe tip of finger with alcohol swab and allow to dry...Pierce the site with lancet...Transfer drop of blood to test strip...Apply pressure to puncture site with gauze pad or alcohol swab...Test blood specimen per manufactures [manufacturer's] guidelines...Read results...Remove gloves...Perform hand hygiene...Clean and disinfect the meter with disinfecting wipes..."

The facility's policy titled Hand Hygiene (revised 2/5/21) documented, "The CDC [Centers for Disease Control and Prevention] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rub (i.e. alcohol-based sanitizer including foam or gel)...To reduce the spread of germs in the healthcare setting..." This policy documented hand hygiene should be performed, "...Before initiating a clean procedure...Before and after patient care...After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin...After contact with inanimate objects (including medical equipment) in the immediate patient vicinity...After glove removal..."

This finding was reviewed with the administrator and director of nursing during a meeting on 4/14/21 at 5:00 p.m.